Schmieding /ILC Solutions Forum on Elder Caregiving

June 2, 2005 ♦ 9 am -12 noon

Schmieding Conference on Elder Homecare

June 2, 2005 ♦ 12 noon - 4 pm

REPORT OF FINDINGS

JUDITH RABIG
THE GREEN HOUSE PROJECT

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SOLUTIONS FOR KEEPING ELDERS AT HOME FOR LIFE

TESTIMONY OF JUDITH RABIG TO THE POLICY COMMITTEE OF THE WHITE HOUSE CONFERENCE ON AGING

My name is Judith Rabig. I am a registered nurse and a gerontologist and I serve as the Executive Director of the national Green House Project, a program targeting radical redesign of the skilled nursing home. I have had the challenge and the privilege of implementing the Green House model at our pilot project site in Tupelo Mississippi. As a result of the positive outcomes for elders in Tupelo our organization is now replicating the Green House model nationally by providing technical assistance and support to adopting organizations in 20 locations in 17 states. This morning I am thankful for the opportunity to tell you about the Green House Project and to ask you to consider the policy changes which would enhance its rapid replication and thereby increase its potential to influence the quality of lives of the 1.7 million American elders who live in nursing homes.

SUMMARY OF FINDINGS

In the United States there are only two groups of individuals we continue to institutionalize for the remainder of their lives; convicted murderers and frail elders, every one else has been provided with the opportunity to live in the community. Nursing homes are the last address for many people in the United States; yet moving to a nursing home is a dreaded event. Residents move to them because of health care needs, yet the quality of health care in nursing homes is problematic despite decades of reform efforts. Reports of inadequacies by consumer groups, government agencies, activists, journalists and families have abounded and the response has been to continue to layer the nursing home industry with federal and state regulations that are well meaning but impotent to eliminate substandard care. An Institute of Medicine study in 1986, recommended new federal standards for resident's rights, quality of life, and changes to quality assessment and enforcement policies. The Nursing Home Reform Act, known colloquially as OBRA 1987, implemented many of the recommendations. However, in a 2001 follow-up study on long-term care quality, the Institute of Medicine concluded that the worthy struggle against manifestations of poor care had made some inroads but the problems of bedsores, malnutrition, infections, de-conditioning, loss of activity of daily living function, improper medication use, high levels of depression and poor quality of life still were prevalent.

It has been long been recognized that it is nearly impossible to provide quality of care or quality of life to an individual in a large institutional setting. Failure to thrive was first noted in infants housed in large orphanages during WW II, and this same problem is plaguing our elders. The Green House model was created to deinstitutionalize frail elders. Our goal is to provide a home where elders live in intentional communities with competent, consistent, well-trained caregivers, and are restored to lives where their needs can be met in an environment that is rich in autonomy, dignity and choice, and where priority is given to their quality of life. Green Houses redesign the foundational philosophy, architecture and organizational structure of the traditional skilled nursing home. Nursing homes are philosophically and programmatically entrenched in the biomedical model, in which elders are primarily, viewed as clinical entities with clinical needs. In contrast, the Green House situates

necessary clinical care within a habilitative, social model without abrogating responsibility for clinical outcomes. The architectural design of a traditional facility is based on the operation and tasks commonly performed in a medical setting, and aims to facilitate the provision of clinical treatments and custodial care, not to accommodate the holistic needs of elders. Long corridors are challenging to frail elders, massive dining rooms do not provide a pleasant dining experience, access to outdoors is limited, and double rooms and shared bathrooms provide little opportunity for privacy or individual pursuits. Green House transforms the nursing home from a single large building to multiple small, self-contained residences for 10 or fewer elders, who have private rooms and full bathrooms, and share communal space, including hearth, dining area, and full kitchen. Multiple Green Houses comprise a nursing home, meeting all NH regulations and working within state reimbursement levels.

The organization of the nursing home is hierarchical and bureaucratic, the size dictating a complex structure and layers of administration and oversight that leave little decision-making in the hands of the elders or their direct caregivers. The Green House redesigns the organization reducing its size. Direct care staff are trained and empowered and work in self-directed work teams to operate the house. They cook meals, do laundry, and provide personal care. Nurses, doctors, and other professionals comprise a visiting clinical support team that meets all necessary clinical needs. A licensed nursing home administrator remains accountable for the outcomes.

In 2003, four Green Houses were built on the campus of a Mississippi Methodist Senior Services retirement community in Tupelo, Mississippi. Forty residents were relocated from the 120-bed nursing home to the Green Houses, including 20 previously living in the locked dementia unit. The Robert Wood Johnson Foundation has supported the pilot project and a research grant from the Commonwealth Fund has allowed Dr. Rosalie Kane and a team of researchers from the University of Minnesota to test the outcomes. The early results have been:

- Elders moved to the Green Houses, many after lengthy institutionalization, without transfer trauma.
- Elders report very high levels of satisfaction with their quality of life, especially as it relates to their privacy and choice.
- Families report high levels of satisfaction with care.
- Dementia related behavior problems have been markedly reduced.
- A decrease in wheelchair use related to the short navigable distances.
- A decrease in urinary incontinence.
- An increase in appetite, food consumption with accompanying weigh gains.
- A decrease in the use of nutritional supplements.
- An increase in elder engagement in personal activities of daily living and in household activities.
- A consistent care staff with a 10% turnover rate in 2 years compared to a national average of 90% annually, and very low levels of absenteeism and injury.

- Two deficiency free state surveys.

- The Tupelo operation has been cost neutral in a 99% Medicaid funded facility.

- Analysis for additional projects demonstrates feasibility under the current reimbursement.

Dr. Kane's team continues to analyze data, and early indications are that there has been an improvement in most of the nationally collected quality indicators.

RECOMMENDATIONS AND REFORMS

The coming demographic shifts, aging nursing home buildings and the long history of nursing home performance failure combine to create an imperative for the widespread implementation of a radical redesigned cost effective clinically sound, high quality alternative model of care for frail elders. Our experiences with organizations replicating the Green House model have informed our understanding of the policy changes, which could assist replication.

- Many state Medicaid systems base reimbursement rates on the case mix of elders. This means that there is a negative financial consequence to adopting organizations i.e. if Green House is adopted and elders improve their reimbursement will *decrease*. We ask that policy be created to remove this disincentive and in fact we support pay for performance reform in reimbursement.

- Many operators plan to replace their aging buildings with new large institutional buildings. Long-term care research supports the small environment. Allowing this new construction is an illogical costly mistake. We need to create policy that acts as a financial disincentive to such activity.

- Obtaining construction capital is challenging for organizations and slows the growth of the Green House model. Policy should create access to low interest construction funding for the Green House and other small environment nursing home replacements.

- The current system of long-term care is fragmented and causes the movement of elders, as their care needs change. These divisions are artificial and arbitrary. Green House and other models have the ability to provide care to frail elders at both the assisted living and skilled levels of care. Policies should support an elder's opportunity to enter a facility that allows them to age in place. Policy should support blended or assessment based reimbursement as an alternative to building license bases reimbursement.

In closing we strongly encourage that the final recommendations of the White House Conference on Aging explicitly support the deinstitutionalization of frail elders by supporting the creation of home settings which are capable of providing skilled nursing care, such as Green House and restricting the construction of new large institutional nursing homes.

I would like to thank the committee for the opportunity to testify here today and I would be happy to answer any questions.